LETTERS *to the Editor*

One Rx at a Time

To the Editor: In recent years there has developed a practice of prescription writing that has a potential for danger. An increased number of physicians have begun to write two or more prescriptions on one prescription blank.

Many pharmacists have complained of this practice to their professional associations and these are some of the reasons they feel it will promote increased error. By law the pharmacist is required to place on each prescription the following information; the Rx number, date filled, the initials of the pharmacist, the quantity dispensed, and a large C must be stamped in the lower right hand corner if a control drug is written. Refills must have the date refilled, the initials of the pharmacist, and the quantity dispensed. By common practice, the pharmacist adds the following information: the brand or manufacturer if a generic drug is written for, the price and several other items if a Medi-Cal or other third party payment plan is indicated. *The crowding of all this information into a relatively small space leads inevitably to errors.*

Errors that can occur are: the labeling of one drug with the directions of another drug which appears on the same blank, the quantity of one drug being dispensed for the other drug, on refills, the patient may order one drug and the other drug is dispensed. These are some of the problems we are concerned about.

We urge all physicians to write just one prescription per blank. Thank you.

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The Adequate Coronary Arteriogram

To the Editor: The widespread demand for coronary arteriography presupposes that the study will reveal the status of the coronary vessels in sufficient detail to guide appropriate medical or surgical therapy. To ensure this happy outcome it is necessary, however, to have clearly in mind what constitutes an adequate coronary arteriogram and to take appropriate measures to see that the result lives up to the expectation. With the abandonment of all indirect methods it may be taken for granted that it is necessary to insert an appropriate catheter into each coronary artery, to inject a quantity of opaque material which is neither so small as to be useless, nor so large as to be dangerous, and to record the resulting image in an acceptable fashion. To accomplish the catheter insertion and the injection requires skill and experience above the ordinary and, not infrequently, a bulldog tenacity. The standard methods are those of Sones[1] and Judkins.[2] Each has its adherents and each is capable of producing excellent coronary artery opacification. Strangely enough, it is in the third and simplest requirement, the recording of the image, that most of the uncertainty and controversy lies and it is this aspect of the examination which is most often inadequate.

It is an accepted principle in radiology as in criminology that two views at right angles constitute a desirable minimum for identification. If the coronary arteries were simple, immobile structures like long bones, any two views at right angles would probably suffice. The coronary arterial patterns are, however, extremely complex with segments and/or branches proceeding in virtually all directions, changing direction frequently, and performing virtually ceaseless acrobatics throughout the filming. Add to this the fact that it is necessary to see every segment of every artery and every branch 1 mm or more in diameter as a bare minimum, and it

becomes evident that two views at right angles cannot possibly constitute an adequate coronary arteriogram. Neither can it be adequately recorded without the high frequency exposures (30 to 60 frames/sec) available with motion picture cameras. Finally, it is necessary that in the viewed image vessels appear at least twice their natural size and preferably more. Otherwise there is no possibility of evaluating the degree of narrowing of a vessel of one millimeter diameter.

Ideally, one would like to see the vessels from all angles but limitations of volume of opaque medium and radiation exposure make this impossible. In our institution we settle for high and low left oblique views and one right oblique view of the right coronary artery, and high and low left oblique views with one postero-anterior and one right oblique view of the left coronary artery. These are all recorded on 35 mm cine film. Sones and Judkins, the acknowledged leaders in the field, record at least three or four views of each coronary artery. It would be rash indeed for the rest of us to suppose that we can get by with less. Furthermore, it is necessary that each view be adequately injected, properly panned, and properly recorded.

There is no doubt that coronary arteriography can be, and frequently is, a tedious and exacting task. Nevertheless, excellent arteriograms are turned out daily in the better laboratories with virtually 100% success. These results are not achieved without proper training, skill, knowledge and determination. It ill-behooves one who is lacking in any of these areas to undertake the task.

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REFERENCES

1. Sones FM Jr, Shirey EK: Cine coronary arteriography. Mod Concepts cardiovasc Dis 31:735, 1962
2. Judkins MP: Selective coronary arteriography—Part I: A percutaneous transfemoral technic. Radiology 89:815, 1967

An Answer to a Call for Help

To the Editor: In response to Dr. Kal's question, "Why this apparent reluctance to ask for psychiatric consultations?" [A call for help (Letter to Editor). Calif Med 117:82, Sep 1972], three points: Firstly, many physicians are admittedly still reluctant to acknowledge psychiatry as "real medicine" and therefore hesitate to make appropriate referrals. Secondly, on the other side of the fence, some psychiatrists who are competent therapists are less skilled as consultants and may have alienated some of their colleagues. But thirdly, and most importantly, many psychiatric patients in Dr. Kal's experience were apparently referred to public health nurses who in turn asked for consultation. Properly qualified public health nurses in cooperation with a consulting psychiatrist are an excellent treatment source and I would encourage expansion of this arrangement.

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Isoniazid Chemoprophylaxis

To the Editor: I received a letter from Dr. J. Yerushalmy, Professor of Biostatistics at the University of California at Berkeley, with regard to our article on Isoniazid Chemoprophylaxis (INH) in the April issue of CALIFORNIA MEDICINE.[1] He reminds us that in the Public Health Service trials of INH chemoprophylaxis in household contacts and mental institutions the mortality rate was actually higher in the INH group than in the controls for non-tuberculosis deaths.[2] This point was discussed by Mrs. Shirley Ferebee who pointed out that by chance the INH group was sicker to begin with and that careful case review provided no basis for implicating INH in any of the deaths.[3] I have not found any more recent information on this subject, but I agree with Dr.